STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155661	A. BUILDING _____ B. WING _____	C 12/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OWEN VALLEY HEALTH CAMPUS	**920 W HWY 46 SPENCER, IN 47460**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00159785.

Complaint IN00159785 - Unsubstantiated due to lack of evidence.

Survey dates: December 17 & 18, 2014

Facility number: 010892
Provider number: 155661
AIM number: 200229560

Survey team:
Susan Worsham, RN- TC

Census bed type:
SNF: 16
SNF/NF: 71
Total: 87

Census payor type:
Medicare: 18
Medicaid: 57
Other: 12
Total: 87

Sample: 03

Owen Valley Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 - 3.1 in regards to the Investigation of Complaint IN00159785.

Quality Review 12/19/14 by Lisa McColly

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE